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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/30/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Total Hip Arthroplasty with 3 days of Inpatient Hospital

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Adverse determination letter 06/18/12
Adverse determination letter 06/29/12
Letter of medical necessity 06/20/12
Preauthorization request form
Precertification request
Surgery scheduling sheet
History and physical reports 02/22/12-07/11/12
MRI right knee 02/10/12
MRI arthrogram left hip 05/23/12
Operative report right knee arthroscopy 04/19/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who reportedly was injured when he slipped at work. He complains of knee pain. The claimant is status post right knee arthroscopy on 04/19/12 with suction irrigation of multiple loose bodies, limited synovectomy, chondroplasty, and partial medial meniscectomy. The claimant was referred for postoperative physical therapy. History and physical report dated 05/31/12 indicated the claimant was seen for recheck of hip pain. MRI arthrogram of left hip on 05/23/12 revealed a small nondisplaced superior labral tear; mild femoral head cuff osteoarthritis; right hip prosthetic artifacts. The claimant reported height to be 75 inches and weight 257 lbs (BMI 32.12). On examination the claimant was noted to

walk with slight limp. He has groin pain with internal rotation of the hip. Flexion is about 120 degrees. Distally the claimant is neurovascularly intact. Treatment options were considered including arthroscopic debridement of labral or continue activities as tolerated, anti-inflammatories, and proceed with left hip arthroplasty and fusion. The claimant was started on NSAIDs. X-rays on 06/07/12 of pelvis were noted to reveal significant joint space narrowing of the left hip compared to previous x-rays 2 months ago. The claimant was seen on 06/07/12 for recheck of left hip pain. The claimant reported physical therapy aggravated his symptoms and anti-inflammatories are not helping his symptoms. He has been having severe groin pain, difficulty walking, working, and negotiating stairs. On examination he can flex 110 degrees; internal and external rotation 15 degrees with severe groin pain. He walks with a limp. X-rays were reviewed and noted to reveal significant joint space narrowing compared to previous x-ray two months ago.

A request for left total hip replacement and 3 day inpatient stay was non-authorized per utilization review dated 06/18/12. It was noted medical documentation submitted for review documented the claimant has gone through physical therapy and taking oral medications; however, there is no documentation the steroid injection has been attempted. The claimant is noted to be under the age but BMI is under 35. Osteoarthritis is documented on x-rays done in treating physician's office, but there is no radiology report. MRI of hip with contrast is noted to demonstrate a small nondisplaced superior labral tear and mild femoral head cuff osteoarthritis. Medical documentation submitted for review did not present any physical therapy notes documenting therapy of left hip other than medical notes stating physical therapy had been performed and was aggravating symptoms. There is no documentation of attempted steroid injection into the hip. MRI only demonstrates mild osteoarthritis of femoral head and small nondisplaced labral tear. There is no documentation of radiologist of osteoarthritis on standing x-rays. As such the request is not medically supported.

A reconsideration request for total hip replacement and inpatient stay was non-authorized per utilization review dated 06/29/12. A peer to peer discussion with Dr. was documented, and it was mutually agreed that Dr would try more nonoperative treatment including cortisone injection before proceeding with the request. A prior utilization review determined the request was non-certified. It was indicated that peer review guidelines indicate for surgery, conservative treatment including medications or steroid injections should be exhausted, plus there should be subjective findings such as limited range of motion, nighttime pain and no pain relief with conservative treatment. The claimant was noted to have used oral medications and performed physical therapy, but there is no documentation of attempted steroid injection. The claimant was under, as peer review guidelines indicate age should be greater than with BMI less than 35. In addition there were no radiology report or x-rays, and MRI of hip with contrast demonstrated small nondisplaced superior labral tear and mild femoral head cuff osteoarthritis. Without documentation of steroid injection and mild osteoarthritis demonstrated by MRI, the request was premature and non-certified. It was noted based on MRI findings of nondisplaced small nondisplaced superior labral tear and mild femoral head cuff osteoarthritis, extensive hip osteoarthritis is not objectified. A subsequent history and physical report dated 07/11/12 indicated the claimant would like to go with left hip intraarticular cortisone injection, but no subsequent progress notes were provided documenting response to treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, medical necessity is not established for left total hip arthroplasty with 3 day inpatient stay. The claimant is a male who was injured on when he slipped. He complained of knee pain and underwent right knee arthroscopy on 04/19/12. He subsequently complained of left hip pain. MRI of the left hip with contrast on 05/23/12 revealed a small non-displaced superior labral tear with mild femoral head cuff osteoarthritis. Right hip prosthetic artifacts also were noted. Records indicate that the claimant had physical therapy which aggravated his symptoms and anti-inflammatories were not helping his symptoms. No physical therapy progress notes were provided documenting the nature and extent of therapy completed to date including the number of sessions completed and

modalities used. No independent radiology report was provided, but x-rays on 06/07/12 were noted to reveal significant joint space narrowing compared to previous x-rays from two months previous. Noting that there is objective evidence of only mild femoral head cuff osteoarthritis with a small non-displaced superior labral tear, and noting that the claimant underwent recent intraarticular cortisone injection to the left hip without follow up documentation, the proposed surgical procedure with left total hip arthroplasty is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)